RULES
OF
THE DEPARTMENT OF COMMERCE AND INSURANCE
DIVISION OF INSURANCE

CHAPTER 0780-1-58
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

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0780-1-58-.01 PURPOSE. The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provision contained in such policies which may be misleading or confusing in connection with the purchase of such policies of with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness coverages to person eligible for Medicare.

Authority: *T.C.A. §56-2-301 and 1992 public Acts, Chapter 735.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992.*

0780-1-58-.02 AUTHORITY. This regulation is issued pursuant to the authority vested in the commissioner under T.C.A. §56-2-301 and 1992 public Acts, Chapter 735.

Authority: *T.C.A. §§56-2-.01 and 1992 Public Acts, Chapter 735.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992.*

0780-1-58-.03 APPLICABILITY AND SCOPE.

(1) Except as otherwise specifically provided in sections 7, 12, 13, 16 and 21, this regulation shall apply to:

(a) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation, and

(Rule 0780-1-58-.03, continued)

(b) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(2) This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455 and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996.*

0780-1-58-.04 DEFINITIONS. For purposes of this rule:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(b) In the case of a group Medicare supplement policy the proposed certificate holder.

(2) "Bankruptcy" means when a Medicare + Choice organization that is not an issuer has filed, or has filed against it a petition for declaration of bankruptcy and has ceased doing business in the state.

(3) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy

(4) "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(5) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater then sixty-three (63) days.

(6) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10 United States Code (CHAMPUS);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A State health benefits risk pool;

(Rule 0780-1-58-.04, continued)

8. A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(b) "Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

(d) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and

2. Hospital indemnity or other fixed indemnity insurance.

(e) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under chapter 55 of title 10, United Stated Code; and

(Rule 0780-1-58-.04, continued)

3. Similar supplemental coverage provided to coverage under a group health plan.

(7) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

(8) "Insolvency" means when an issuer has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(9) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(10) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(11) "Medicare+Choice" plan "means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

(a) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans;

(b) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(c) Medicare+Choice private fee-for-service plans.

(12) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(13) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 28, 1996. Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.05 POLICY DEFINITIONS AND TERMS.

(1) No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

(Rule 0780-1-58-.05, continued)

(a) Accident, Accidental Injury, or Accidental Means shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: " Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) Benefit Period or Medicare Benefit Period shall not be defined more restrictively than as defined in the Medicare program.

(c) Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility shall not be defined more restrictively than as defined in the Medicare program.

(d) Health Care Expenses means expenses of health maintenance organizations associated with the delivery of health care services which expenses are analogous to incurred losses of insurers. Expenses shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and
7. Claims processing costs.

(e) Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(f) Medicare shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted of Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof;" or words of similar import.

(g) Medicare Eligible Expenses shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(h) Physician shall not be defined more restrictively than as defined in the Medicare program.

(i) Sickness shall not be defined to be more restrictive than the following:

1. "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

(Rule 0780-1-58-.05, continued)

2. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-4-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996.*

0780-1-58-.06 POLICY PROVISIONS.

(1) Except for permitted preexisting condition clauses as described in rules 0780-1-58-.07(a) 1. and 0780-1-58-.08(a) 1., no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(3) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996.*

0780-1-58-.07 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992.

(1) No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. This section is intended to clarify that the following standards contained in Tennessee Rules and Regulations Chapter 0780-1-58-.08, repealed by these regulations, shall continue to apply to Medicare supplement insurance policies or certificates issued for delivery prior to July 1, 1992.

(a) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any

changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

4. A "nonconcellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(i) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(ii) Be cancelled or nonrenewed by the issure solely on the grounds of deterioration of health.

5. (i) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(ii) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(iv), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in rule 0780-1-58-.08(b).

(iii) If membership in a group is terminated, the issuer shall:

(I) Offer the certificate holder the conversion opportunities described in Subparagraph (ii); or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(iv) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the old group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

(b) Minimum Benefit Standards.

(Rule 0780-1-58-.07, continued)

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve day;

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

6. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations). Unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996.*

0780-1-58-.08 BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVEREY AFTER JULY 1, 1992

(1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(a) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

   (i) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

   (ii) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

   (iii) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (v) below, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)

      (I) Provides for continuation of the benefits contained in the group policy, or

      (II) Provides for benefits that otherwise meet the requirements of this subsection.

   (iv) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

      (I) Offer the certificate holder the conversion opportunity described in subparagraph (iii) above, or

      (II) At the option of the group policy holder, offer the certificate holder continuation of coverage under the group policy.

   (v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

7. (i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is

determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

(ii) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) Reinstitution of such coverages:

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(b) Standards for Basic (Core) Benefits Common to All Benefit Plans. Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostick Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5. Coverage for the coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(c) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans “B” through “J” only as provided by rule 0780-1-58-.09 of this regulation.

(Rule 0780-1-58-.08, continued)

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

7. Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

8. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250) and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit: Coverage for the following preventive health services:

   (i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (ii) and patient education to address preventive health care measures.

   (ii) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

      (I) Fecal occult blood test or digital rectal examination, or both;

      (II) Mammogram;

(Rule 0780-1-58-.08, continued)

(III) Dipstick urinalysis for hematurea, bacteriuria and proteinauria;

(IV) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(V) Serum cholesterol screening (every five (5) years);

(VI) Thyroid function test;

(VII) Diabetes screening.

(iii) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diptheria booster (every ten (10) years).

(iv) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(i) For purposes of this benefit, the following definitions shall apply:

(I) Activities of daily living include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(II) Care Provider means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(III) Home shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured’s place of residence.

(IV) At-home recovery visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(ii) Coverage Requirements and Limitations

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

(Rule 0780-1-58-.08, continued)

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to:

I. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

II. The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

III. One thousand six hundred dollars ($1,600) per calendar year.

IV. Seven (7) visits in any one week.

V. Care furnished on a visiting basis in the insured's home.

VI. Services provided by a care provider as defined in this section.

VI. At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for:

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

11. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.09 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS.

(1) An issuer shall make available to each prospective policy holder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in rule 0780-1-58-.08(1)(b).

(Rule 0780-1-58-.09, continued)

(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may permitted in rule 0780-1-58-.08(1)(c) 11.

(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in rule 0780-1-58-.04. Each benefit shall be structured in accordance with the format provided in rule 0780-1-58-.08(1)(b) and (c) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(4) An issuer may use, in addition to the benefit plan designations required in Paragraph (3) above, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the basic core benefits common for all benefits plans, as defined in rule 0780-1-58-.08(1)(b).

(b) Standardized Medicare supplement benefit plan "B" shall include only the following: the core benefit defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A Deductible as defined in rule 0780-1-58-.08(1)(c) 1.

(c) Standardized Medicare supplement benefit plan "C" shall include only the following: the core benefit as defined in rule 0780-1-58-.08(1)(b) plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in rule 0780-1-5-.08(1)(c) 1., 2., 3. And 8. Respectively.

(d) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b) plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in rule 0780-1-58-.08(1)(c) 1., 2., 8. and 10. respectively.

(e) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in rule 0780-1-58-.08(1)(c) 1., 2., 8. and 9. respectively.

(f) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in rule 0780-1-58-.08(1)(c) 1., 2., 3., 5. and 8. respectively.

(g) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in rule 0780-1-58-.08(1)(c) 1., 2., 3., 5. and 8. respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the

(Rule 0780-1-58-.09, continued)

Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(h) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, skilled nursing facility crew, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in rule 0780-1-58-.08(1)(c) 1., 2., 4., 8. and 10. respectively.

(i) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in rule 0780-1-58-.08(1)(c) 1., 2., 6. and 8. respectively.

(j) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in rule 0780-1-58-.08(1)(c) 1., 2., 5., 6., 8. and 10. respectively.

(k) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in rule 0780-1-58-.08(1)(b), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country , preventive medical care and at-home recovery benefit as defined in rule 0780-1-58-.08(1)(c) 1., 2., 3., 5., 7., 8., 9. and 10. respectively.

(l) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in rule 0780-1-58-08(1)(b), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Plan B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefits as defined in rule 0780-1-58-.08(1)(c) 1., 2., 3., 5., 7., 8., 9. and 10. respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.10 MEDICARE SELECT POLICIES AND CERTIFICATES

(1) (a) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(b) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(2) For the purposes of this section:

(a) Complaint means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(b) Grievance means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(c) Medicare Select issuer means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(d) Medicare Select Policy or Medicare Select Certificate mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(e) Network Provider means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(f) Restricted Network Provision means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) Service Area means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

(3) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(4) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the commissioner.

(5) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

1. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

2. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

3. There are written agreements with network providers describing specific responsibilities.

(Rule 0780-1-58-.10, continued)

4. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

5. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be utilized.

(d) A description of the quality assurance program, including:

1. The formal organization structure;

2. The written criteria for selection, retention and removal of network providers; and

3. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the issuer to comply with Paragraph (9).

(g) Any other information requested by the commissioner.

(6) (a) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

(b) An updated list of network providers shall be filed with the commissioner at least quarterly.

(7) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(b) It is not reasonable to obtain such services through a network provider.

(8) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for Covered services that are not available through network providers.

(9) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and Premiums of the Medicare Select policy or certificate with:

(Rule 0780-1-58-.10, continued)

1. Other Medicare supplement policies or certificates offered by the issuer: and

2. Other Medicare Select policies or certificates.

(b) A description (including address, phone number and hours of operation) of the network Providers, including primary care physicians, specialty physicians, hospitals and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance And deductibles when providers other than network providers are utilized.

(d) A description of coverage for emergency and urgently needed care and other out-of-Service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(g) A description of the Medicare Select issuer's quality assuarance program and grievance Procedure.

(10) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection (9) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(11) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving Written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(a) The grievance procedure shall be described in the policy and certificates and in the outline coverage.

(b) At the time the policy or certificate is issued, the issuer shall provide detailed Information to the policyholder describing how a grievance may be registered with the issuer.

(c) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(d) If a grievance is found to be valid, corrective action shall be taken promptly.

(e) All concerned parties shall be notified about the results of a grievance.

(f) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(12) At the time of the initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer.

(13) (a) At the request of an individual insured under a Medicare Select policy of certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to Purchase a

(Rule 0780-1-58-.10, continued)

Medicare supplement policy or certificate offered by the issuer which has Comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of Insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(b) For the purposes of the Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of the subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(14) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(a) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(b) For the purposes of this Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of the subparagraph, a significant benefit means coverage for the Medicare Part a deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(15) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal Agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.*
Administrative History: *Original rule filed August 15, 1996; effective October 29, 1996.*

0780-1-58-.11 OPEN ENROLLMENT

(1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement Policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all persons who qualify under this subsection without regard to age.

(2) (a) If an applicant qualifies under Paragraph (1) and submits an application during the time period referenced in Paragraph (1) and, as of the date of application, has had a continuous period of creditable coverage of at lease six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(Rule 0780-1-58-.11, continued)

(b) If the applicant qualifies under Paragraph (1) and submits an application during the time period referenced in Paragraph (1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in Paragraph (2) and Rule 0780-1-58-.23, Paragraph (1) shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Authority: T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss. ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.12 GUARANTEED FOR ELIGIBLE PERSONS

(1) Guaranteed Issue

(a) Eligible persons are those individuals described in Paragraph (2) who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in Paragraph (2), and who submit evidence of the date of termination or termination or disenrollment with the application for a Medicare supplement policy.

(b) With respect to eligible persons, an issuer shall not deny or condition the issuance or Effectiveness of a Medicare supplement policy described in Paragraph (3) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(2) Eligible Persons

An eligible person is an individual described in any of the following paragraphs:

(a) The individual is enrolled under an employee welfare benefit plan that provides health Benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(b) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply:

1. The organization's or plan's certificate (under this part) has been terminated or The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

2. The individual is no linger eligible to elect the plan because of a change in the Individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior

as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

3. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's Behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

4. The individual meets such other exceptional conditions as the Secretary may provide.

(c) 1. The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 (Medicare risk or cost);

(ii) A similar organization operating under demonstration project Authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); and

(iv) An organization under a Medicare Select policy; and

2. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Rule 0780-1-58-.12(2)(b).

(d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

1. (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

2. The issuer of the policy substantially violated a material provision of the policy; or

3. This issuer, or an agent or other entity acting on the issuer's behalf, materially Misrepresented the policy's provisions in marketing the policy to the individual;

(e) 1. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833(a)(1)(health care prepayment plan), or a Medicare Select policy; and

(Rule 0780-1-58-.12, continued)

2. The subsequent enrollment under part 1, is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

(f) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare+Choice plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(3) Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(a) Rule 0780-1-58.12(2)(a)(b)(c) and (d) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

(b) Rule 0780-1-58.12(2)(e) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (3)(a).

(c) Rule 0780-1-58-.12(2)(f) shall include any Medicare supplement policy offered by any Issuer.

(4) Notification provisions

(a) At the time of an event described in Paragraph (2) of this rule because of which an Individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this rule, and of the obligations of issuers of Medicare supplement policies under Paragraph (1). Such notice shall be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in Paragraph (2) of this rule because of which an Individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this rule, and of the obligations of issuers of Medicare supplement policies under Rule 0780-1-58-.12(1). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1453, 56-7-1455, and 1992 Public Acts, Chapter 735, Section 3.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.13 STANDARDS FOR CLAIMS PAYMENT.

(1) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise

(Rule 0780-1-58-.13, continued)

required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(c) Paying the participating physician or supplier directly.

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Compliance with the requirements set forth in Subsection (1) above shall be certified on the Medicare supplement insurance experience reporting form.

Authority: *T.C.A. §56-2-301 and 1992 Public Acts, Chapter 735, Section 3.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.12) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.14 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

(1) Loss Ratio Standards

(a) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

1. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or

2. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(b) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premium comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(2) Refund or Credit Calculation

(a) An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(b) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(c) For the purposes of this Paragraph, policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.

(d) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a diminished level. The refund shall include interest from the end of the calendar year to the date of the refund or credit rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(3) Annual Filing of Premium Rates

(a) An issuer of Medicare supplement policies and certificates issued before or after the effective date of Chapter 0780-1-58 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An unexpected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(b) As-soon-as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of the state:

1. (i) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing;

(ii) An issuer shall make the premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(iii) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(Rule 0780-1-58-.14, continued)

2. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(4) Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Chapter 0780-1-58 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301,56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. (Formerly 0780-1-58-.13) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.15 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

(1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(2) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(3) (a) Except as provided in Paragraph (b) below, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(b) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

1. The inclusion of new or innovative benefits;
2. The addition of either direct response or agent marketing methods;
3. The addition of either guaranteed issue or underwritten coverage;
4. The offering of coverage to individuals eligible for Medicare by reason of disability.

(c) For the purposes of this section, a “type” means an individual policy or a group policy.

(4) (a) Except as provided in subparagraph 1. Below, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

1. An issuer may discontinue the availability of a policy form or certificate form is the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the

(Rule 0780-1-58-.15, continued)

notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph 1, above shall not file for approval of a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance may be reduced if the commissioner determines that a shorter period is appropriate

(b) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purpose of this subsection.

(c) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (a) unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(5) (a) Except as provided in Paragraph (b) below, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in rule 0780-1-58-.13.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 A.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. (Formerly 0780-1-58-.14) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.16 PERMITTED COMPENSATION ARRANGEMENTS

(1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(3) No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(Rule 0780-1-58-.16, continued)

(4) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-4-1431, 56-7-1455 and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. (Formerly 0780-1-58-.15) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.17 REQUIRED DISCLOSURE PROVISIONS.

(1) General Rules

(a) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits; all riders or endorsements assed to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import.

(d) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(f) 1. Issuers of accident and sickness policies or certificates which provide hospital medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Guide, shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers,

delivery of the Guide, shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

2. For the purpose of this subparagraph, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(2) Notice Requirements

(a) As-soon-as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

2. Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(b) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(c) The notices shall not contain or be accompanied by any solicitation.

(3) Outline of Coverage Requirements for Medicare Supplement Policies.

(a) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and , except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and

(b) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: **NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.**

(c) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(d) The following items shall be included in the outline of coverage in the order prescribed below:

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____[insert letters of plans being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services, applicable copayments.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)	
				Preventive Care						Preventive Care	

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1500] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

(Rule 0780-1-58-.17, continued)

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "*The Medicare Handbook*" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to rule 0780-1-58-.09(4)]

(Rule 0780-1-58-.17, continued)

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$0	$[764](Part A deductible)
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	$0	Up to $[95.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN A

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(Rule 0780-1-58-.17, continued)

PLAN B

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764](Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	$0	Up to $[95.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN B

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(Rule 0780-1-58-.17, continued)

PLAN C

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764](Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN C

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

(Rule 0780-1-58-.17, continued)

OTHER BENEFITS– NOT COVERED BY MEDICARE

FOREIGN TRAVEL– NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$0
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

(Rule 0780-1-58-.17, continued)

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN D

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

(Rule 0780-1-58-.17, continued)

PLAN D (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES– NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan	$0	Actual charges to $40 a visit	Balance
– Benefit for each visit			
– Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
– Calendar year maximum	$0	$1,600	

OTHER BENEFITS– NOT COVERED BY MEDICARE

FOREIGN TRAVEL– NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(Rule 0780-1-58-.17, continued)

PLAN E

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN E

MEDICARE (PART B)– MEDICAL SERVICES– PER BENEFIT PERIOD

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

(Rule 0780-1-58-.17, continued)

PLAN E (continued)

OTHER BENEFITS– NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT– NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

(Rule 0780-1-58-.17, continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $[382] a day	$[382] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (cont.)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**
****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued

(Rule 0780-1-58-.17, continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (cont.)
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $100 of Medicare approved Amounts* Remainder of Medicare approved Amounts	 100% $0 80%	 $0 $100 (Part B deductible) 20%	 $0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE, ** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services beginning during the first 60 days of each trip outside the USA First $250 each Calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum

(Rule 0780-1-58-.17, continued)

PLAN G

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN G

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

(Rule 0780-1-58-.17, continued)

PLAN G (continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B deductible) $0
AT-HOME RECOVERY SERVICES– NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan – Benefit for each visit – Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) – Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed 7 each week $1,600	Balance

OTHER BENEFITS– NOT COVERED BY MEDICARE

FOREIGN TRAVEL– NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

(Rule 0780-1-58-.17, continued)

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN H

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	0%	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

(Rule 0780-1-58-.17, continued)

PLAN H (continued)

OTHER BENEFITS– NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL– NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRE-SCRIPTION DRUGS– NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%– $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

(Rule 0780-1-58-.17, continued)

PLAN I

MEDICARE (PART A)– HOSPITAL SERVICES– PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts	$0	$0
First 20 days	All but $[95.50] a day	Up to $[95.50] a day	$0
21st thru 100th day	$0	$0	All costs
101st day and after			
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(Rule 0780-1-58-.17, continued)

PLAN I

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

(Rule 0780-1-58-.17, continued)

PLAN I (continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B deductible) $0
AT-HOME RECOVERY SERVICES– NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan – Benefit for each visit – Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) – Calendar year maximum	$0 $0 0	Actual charges to $40 a visit Up to the number of Medicare-approved visits, not to exceed 7 each week $1,600	Balance

OTHER BENEFITS– NOT COVERED BY MEDICARE

FOREIGN TRAVEL– NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRE-SCRIPTION DRUGS– NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	$0 $0 $0	$0 50%– $1,250 calendar year maximum benefit $0	$250 50% All costs

(Rule 0780-1-58-.17, continued)

PLAN J OR HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

**** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$0
61st thru 90th day	All but $[191] a day	$[191] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

(Rule 0780-1-58-.17, continued)

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

MEDICARE (PART B)– MEDICAL SERVICES– PER CALENDAR YEAR

*** Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**
****This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE, ** YOU PAY
MEDICAL EXPENSES– IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

(Rule 0780-1-58-.17, continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $100 (Part B deductible) 20%	$0 $0 $0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES– NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan – Benefit for each visit – Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) – Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	Balance

(continued)

(Rule 0780-1-58-.17, continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

PARTS A & B (continued)

OTHER BENEFITS– NOT COVERED BY MEDICARE

FOREIGN TRAVEL– NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS– NOT COVERED BY MEDICARE First $250 each calendar year Next $6,000 each calendar Year Over $6,000 each calendar Year	 $0 $0 $0	 $0 50%– $3,000 calendar year maximum benefit $0	 $250 50% All costs
***PREVENTIVE MEDICAL CARE BENEFIT– NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. Repealed and new rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. (Formerly 0780-1-58-.16) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.18 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE

(1) Application forms shall include the following questions designed to elicit Information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary

application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(a) You do not need more than one Medicare supplement policy.

(b) If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(d) The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested with 90 days of Losing Medicaid eligibility.

(e) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).

[Questions]

(2) To the best of your knowledge,

(a) Do you have another Medicare supplement policy or certificate in force?

1. If so, with which company?
2. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

(b) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

1. If so, with which company?
2. What kind of policy?

(c) Are you covered for medical assistance through the state Medicaid program?

1. As a Specified Low Income Medicare Beneficiary (SLMB)?
2. As a Qualified Medicare Beneficiary (QMB)?
3. For other Medicaid medical benefits?

(3) Agents shall list any health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.
(b) List policies sold in the past five (5) years which are no longer in force.

(4) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the insurer upon delivery of the policy.

(Rule 0780-1-58-.18, continued)

(5) Upon determining that a sale will involve a replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sole without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(6) The notice required by Subsection (5) above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate your existing Medicare supplement insurance and replace it with a policy to be issued by [company name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Other. (Please specify.)_____
_____
_____
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisiting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(Rule 0780-1-58-.18, continued)

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

Authority: *T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455, and 56-1-1457; 42 U.S.C Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989. New rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. (Formerly 0780-1-58-.17) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.19 FILING REQUIREMENTS FOR ADVERTISNG.

(1) An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the commissioner for review or approval by the commissioner by the proposed effective date.

(2) The commissioner may notify the insurer in writing if she determines that advertising material submitted in accordance with paragraph (1) of this rule fails to conform with the provisions of this rule, T.C.A. §§56-7-1431(b) and 56-8-101 et seq., or has been determined otherwise unfair or deceptive. Such notice shall specify the reason(s) for the commissioner's determination and shall afford the insurer a right to a hearing in compliance with the Tennessee Uniform Administrative Procedures Act, T.C.A. §4-5-301 et seq.

(3) The commissioner may order any insurer to cease and desist from using any Advertisement, after notice and hearing, that is determined to violate this Chapter. Any violation of the Chapter subjects the insurer to penalty as outlined in T.C.A. §56-7-1429(a)(1).

(4) Failure of the commissioner to issue a notice pursuant to paragraph (1) of this rule shall not relieve any insurer of responsibility for compliance with this Chapter, nor will this failure waive any right of the commissioner to bring an action against an insurer for violation of this Chapter.

Authority: *T.C.A. §§56-2-301, 56-7-1429, 56-7-1431, and 1992 Public Acts, Chapter 735, Sections 3 and 7.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. New rule filed*

(Rule 0780-1-58-.19, continued)

November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.18) Amendment filed October 25, 1999; effective January 3, 2000.

0780-1-58-.20 STANDARDS FOR MARKETING.

(1) An issuer, directly or through its producers, shall:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp or other appropriate means, on the first page of the following:

"NOTICE TO BUYER: This policy may not cover all of your medical expenses."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(e) Establish auditable procedures for verifying compliance with this Part (1).

(2) In addition to the practices prohibited in T.C.A. §56-8-101 et seq., the following acts and practices are prohibited:

(a) Twisting. Knowingly making any misleading representation or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, to convert any insurance policy or to take out a policy of insurance with another insurer.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(3) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Authority: *T.C.A.§§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1455 and 56-1-1457; 42 U.S.C. Section 1395ss.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. New rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. Amendment filed August 15, 1996; effective October 29, 1996. (Formerly 0780-1-58-.19) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.21 APPROPRIATENESS OF RECEMMENDED PURCHASE AND EXCESSIVE INSURANCE.

(1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of recommend purchase or replacement.

(Rule 0780-1-58-.21, continued)

(2) Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Authority: *T.C.A. §56-2-301 and 1992 Public Acts, Chapter 735, Sections 3 and 5.* ***Administrative History:*** *Original rule filed August 14, 1989; effective September 28, 1989. New rule filed November 26, 1990; effective January 10, 1991. Repealed and new rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.20) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.22 REPORTING OF MULTIPLE POLICIES.

(1) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement insurance policy or certificate.

(a) Policy and certificate number, and

(b) Date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

(3) The required form is attached as Appendix B.

Authority: *T.C.A. §56-2-301and 1992 Public Acts, Chapter 735, Section 3 and 5.* ***Administrative History:*** *Original rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.21) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.23 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

(1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement Policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Authority: *T.C.A. §56-2-301 and 1992 Public Acts, Chapter 735.* ***Administrative History:*** *Original rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.22) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.24 SEPARABILITY. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Authority: *T.C.A. §56-2-301 and 1992 Public Acts, Chapter 735.* ***Administrative History:*** *Original rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.23) Amendment filed October 25, 1999; effective January 3, 2000.*

0780-1-58-.25 EFFECTIVE DATE. These rules shall replace the emergency rules which were effective on April 28, 1996.

(Rule 0780-1-58-.25, continued)

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR

TYPE[1]_____ SMSBP[2]_____

For the State of …… Company Name ……..

NAIC Group Code ……. NAIC Company Code ……..

Address …….. Person Completing Exhibit ……

Title …….. Telephone Number ……..

Line			(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience			
	a.	Total (all policy years)	_____	_____
	b.	Current year's issues[5]	_____	_____
	c.	Net (for reporting purposes=1a-1b)	_____	_____
2.	Past Years' Experience (all policy years)		_____	_____
3.	Total Experience (Net Current Year + Past Year)		_____	_____
4.	Refunds Last Year (Excluding Interest)			_____
5.	Previous Since Inception (Excluding Interest)			_____
6.	Refunds Since Inception (Excluding Interest)			
7.	Benchmark Ration Since Inception (SEE WORKSHEET FOR RATIO 1)			_____
8.	Experienced Ration Since Inception Total Actual Incurred Claims (line 3, col b) = Ration 2 / Total Earned Prem. (line 3, col a) —Refunds Since Inception (line 6)			_____
9.	Life Years exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.			_____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2] "SMSBP =Standardized Medicare Supplement Benefit Plan – Use P" for pre-standardized plans.
[3] Includes Model Loadings and Fees Charged
[4] Excludes Active Life Reserves
[5] This is to be used as Issue Year Earned Premium for Year 1 of next year's Worksheet for Calculation of Benchmark Ratios

(Rule 0780-1-58-.25, Appendix A, continued)

10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table
Life Years Exposed

Since Inception	Tolerance
10,000+	0.0%
5,000 —9,999	5.0%
2,500 —4,999	7.5%
1,000 —2,499	10.0%
500 —999	15.0%

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR

TYPE[1]…….. SMSBP[2]……

For the State of …… Company Name ……..

NAIC Group Code …….. NAIC Company Code……..

Address …… Person Completing Exhibit ……

Title …… Telephone Number ……

1. Adjustment to Incurred Claims for Credibility
Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims
[Total Earned Premiums (line 3, col. A) —Refunds Since Inception (line 6)] X Ratio 3 (line 11) _____

13. Refund
Total Earned Premiums (line 3, col. A) —Refunds Since Inception _____
(line 6) —Adjusted Incurred Claims (line 12) / _____
Benchmark Ratio (Ratio 1) _____

If the amount on lien 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name —Please Type

_____
Title Please Type

_____
Date

_____

(Rule 0780-1-58-.25, Appendix A, continued)

REPORTING FORM THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE[1] SMSB[2]
For the State of Company Code
Address Person Completing Exhibit
Title Telephone Number

(a)[3] Year	(b)[4] Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumula-tive Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(I) Cumula-tive loss ratio	(j) (h)x(I)	(o)[5] Policy Year Loss Ratio
1				0.507		0.000		0.000		0.46
2		2.770		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (1+n) / (k+m): _____

(Rule 0780-1-58-.25, Appendix A, continued)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO
SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR
TYPE[1] SMSBP[2]
For the State of Company Name
NAIC Group Code NAIC Company Code
Address Person Completing Exhibit
Title Telephone Number

(a)[3] Year	(b)[4] Premium	(c) Factor	(d) (b)x(c)	(e) Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(I) Loss Ratio	(j) (h)x(I)	(o)[5] Earned Cumula-tive Policy Year Loss Ratio
1		2.770		0.442		0.0000		0.0000		0.40
2		4.175		0.493		0.0000		0.0000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2] "SMBSP" =Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans
[3] Year 1 is the current calendar year –1. Year 2 is the current calendar year-2 (etc.)(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year
[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(Rule 0780-1-58-.25, continued)

Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l+n) / (k)+(m): _____

APPENDIX B
FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____ Due March 1, annually

The purposes of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

(Rule 0780-1-58-.25, continued)

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Rule 0780-1-58-.25, Appendix C, continued)

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Authority: *42 U.S.C. Section 1395ss, T.C.A. §§4-5-101 et seq., 56-2-301, 56-7-1431, 56-7-1453, 56-7-1455, and 56-7-1457.* ***Administrative History:*** *Original rule filed September 16, 1992; effective November 1, 1992. (Formerly 0780-1-58-.24) Amendment filed October 25, 1999; effective January 3, 2000.*